Affidavit of Records Custodian of
The Back & Neck Institute

STATE OF TEXAS §
§
COUNTY OF EL PASO §

Before me, the undersigned authority, personally appeared Lucia Orona, who, being by me duly sworn, deposed as follows: (Custodian of Records Name)

My name is Lucia Orona I am of sound mind and capable of making this affidavit, and personally acquainted with the facts herein stated.

I am the custodian of records for **The Back & Neck Institute.** Attached to this affidavit are records that provide an itemized statement of the service and the charge for the service that **The Back & Neck Institute** provided to **DAWN CORDERO** on **October 11, 2016 to Present**, the attached records are part of this affidavit.

The attached records are kept by **The Back & Neck Institute** in the regular course of business, and it was the regular course of business of **The Back & Neck Institute** for an employee or representative of for **The Back & Neck Institute**, with knowledge of the service provided, to make the record or transmit information to be included in the record. The records were made in the regular course of business at or near the time reasonably soon after the time the service was provided. The records are the original or duplicate of the original.

The services provided were necessary and the amount charged for the services was reasonable at the time and place that the services were provided.

The total amount paid for the services was $ 0 and the amount currently unpaid but which for **The Back & Neck Institute** has a right to be paid after any adjustments or credits is $ 18,490.00

Affiant (Custodian of Records Signature)

SWORN TO AND SUBSCRIBED before me on the 4 day of June, 2018

Valeria A. Flores
Notary ID: 131364003
My Commission Expires:
December 1, 2021

Notary Public, State of Texas

Notary's printed name: Valeria Flores My commission expires: 12/01/2021

RECEIVED
FEB 13 2019
BY:

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 SEX M [ ] F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) HOWDYS
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street) 12460 MONTWOOD DR
CITY EL PASO	STATE TX	8. RESERVED FOR NUCC USE	CITY 	STATE
ZIP CODE 79928	TELEPHONE (Include Area Code) ( )		ZIP CODE 	TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:		11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO		a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [X] YES [ ] NO PLACE (State)		b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [ ] YES [X] NO		c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)		d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

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SIGNED SIGNATURE ON FILE DATE 10/17/17

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
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PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL. 431	15. OTHER DATE QUAL. 454 MM DD YY 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA	17a. 0B MDK4281TX 17b. NPI 1356303150	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M24852 B. M79605 C. M7062 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 09 28 17	09 28 17	11		99245		ABC	750 00	1		NPI	1356303150
2 09 28 17	09 28 17	11		73502	LT	ABC	250 00	1		NPI	1356303150
3										NPI	
4										NPI	
5										NPI	
6										NPI	

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742930387 [ ] [X]	CORDA005 129879	[X] YES [ ] NO	$ 100000	$	

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SIGNATURE ON FILE SIGNED 10/17/17 DATE	THE BACK NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b. OBMDK4281TX

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SIGNED SIGNATURE ON FILE DATE 07/13/18

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1 06 22 18	06 22 18	11		99215		A B C	500 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
742930387 [ ] [X]	CORDA005 137026	[X] YES [ ] NO	$ 500 00	$	

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801 MYRTLE AVE SUITE 100
EL PASO TX 79901

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1	07 26 18	07 26 18	24		27095		ABC	2500 00	1		NPI	1356303150
2	07 26 18	07 26 18	24		73525	26 59	ABC	500 00	1		NPI	1356303150
3	07 26 18	07 26 18	24		73502	26 59	ABC	250 00	1		NPI	1356303150
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 ☒	26. PATIENT'S ACCOUNT NO. CORDA005 137836	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☒ YES ☐ NO	28. TOTAL CHARGE $ 325 00	29. AMOUNT PAID $	30. Rsvd for NUCC Use
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CARRIER — PATIENT AND INSURED INFORMATION — PHYSICIAN OR SUPPLIER INFORMATION

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1 08 13 18	08 13 18	11		99215		ABC	500 00	1		NPI	1356303150
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19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
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24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 01 18	11 01 18	11		72148		A B C	2250 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
742930387 [X]	CORDA005 140943	[X] YES [ ] NO	$ 225000	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNATURE ON FILE SIGNED 11/27/18 DATE	THE BACK NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	(915) 8818264 THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CORDERO, DAWN

3. PATIENT'S BIRTH DATE MM DD YY: 07 05 1995 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CORDERO, DAWN

5. PATIENT'S ADDRESS (No., Street): 1880 JOAN FRANCIS DR

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1880 JOAN FRANCIS DR

CITY: EL PASO STATE: TX

8. RESERVED FOR NUCC USE

CITY: EL PASO STATE: TX

ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )

ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 05 1995 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: FLORES TAWNEY ACOSTA PC

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 12/11/18

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 11 16 QUAL. 431

15. OTHER DATE QUAL. 454 MM DD YY: 09 28 17

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ROBERT E URREA MDPA

17a. 0B MDK4281TX

17b. NPI 1356303150

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ZZ207X00000X

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. M24852 B. M79605 C. M7062 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 11 14 18	11 14 18	11		99215		A-BC	500 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X]: 742930387

26. PATIENT'S ACCOUNT NO.: CORDA005 141510

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 500 00

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE

SIGNED 12/11/18 DATE

32. SERVICE FACILITY LOCATION INFORMATION

THE BACK NECK INSTITUTE
6211 EDGEMERE SUITE 1
EL PASO TX 79925-3413

a. 1265499578 b.

33. BILLING PROVIDER INFO & PH # (915) 8818264

THE BACK & NECK INSTITUTE
6211 EDGEMERE SUITE 1
EL PASO TX 79925-3413

a. 1265499578 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
						X	

2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	3. PATIENT'S BIRTH DATE MM DD YY / SEX 07 05 1995 M F X	4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other X	7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR
CITY: EL PASO / STATE: TX	8. RESERVED FOR NUCC USE	CITY: EL PASO / STATE: TX
ZIP CODE: 79928 / TELEPHONE (Include Area Code): ( )		ZIP CODE: 79928 / TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) YES / X NO	a. INSURED'S DATE OF BIRTH MM DD YY / SEX 07 05 1995 M F X
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? YES / X NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? X YES / NO	c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES / X NO *If yes*, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/09/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431	15. OTHER DATE QUAL 454 MM DD YY 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA	17a. 0B MDK4281TX 17b. NPI 1356303150	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? YES / X NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M545 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL	J. RENDERING PROVIDER ID. #
1	12 20 18	12 20 18	24		64483		A	5000 00	1		NPI	1356303150
2	12 20 18	12 20 18	24		64450	59	A	1000 00	1		NPI	1356303150
3	12 20 18	12 20 18	24		72100	26 59	A	500 00	1		NPI	1356303150
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN 742930387 X	26. PATIENT'S ACCOUNT NO. CORDA005 142404	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) X YES NO	28. TOTAL CHARGE $ 650000	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 01/09/19	32. SERVICE FACILITY LOCATION INFORMATION BASSETT SURGERY CENTER 6211 EDGEMERE STE2 EL PASO TX 79925-3413 a. 1477517316 b.	33. BILLING PROVIDER INFO & PH # (915) 8818264 THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.			

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): CORDERO, DAWN

3. PATIENT'S BIRTH DATE MM DD YY: 07 05 1995 SEX M [ ] F [X]

4. INSURED'S NAME (Last Name, First Name, Middle Initial): CORDERO, DAWN

5. PATIENT'S ADDRESS (No., Street): 1880 JOAN FRANCIS DR

6. PATIENT RELATIONSHIP TO INSURED: Self [X] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street): 1880 JOAN FRANCIS DR

CITY: EL PASO STATE: TX

8. RESERVED FOR NUCC USE

CITY: EL PASO STATE: TX

ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )

ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: 07 05 1995 SEX M [ ] F [X]

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? YES [X] NO [ ]

c. INSURANCE PLAN NAME OR PROGRAM NAME: FLORES TAWNEY ACOSTA PC

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED: SIGNATURE ON FILE DATE: 01/16/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED: SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY: 10 11 16 QUAL. 431

15. OTHER DATE QUAL. 454 MM DD YY: 09 28 17

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE: DN ROBERT E URREA MDPA

17a. OR MDK4281TX

17b. NPI 1356303150

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC): ZZ207X00000X

20. OUTSIDE LAB? YES [ ] NO [X] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. M24852 B. M79605 C. M7062 D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 03 19	01 03 19	11		99215		ABC	500 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN: 742930387 [X]

26. PATIENT'S ACCOUNT NO.: CORDA005 142718

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [X] NO [ ]

28. TOTAL CHARGE: $ 50000

29. AMOUNT PAID: $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNATURE ON FILE

SIGNED 01/16/19

32. SERVICE FACILITY LOCATION INFORMATION

THE BACK NECK INSTITUTE
6211 EDGEMERE SUITE 1
EL PASO TX 79925-3413

a. NPI 1265499578 b.

33. BILLING PROVIDER INFO & PH # (915) 8818264

THE BACK & NECK INSTITUTE
6211 EDGEMERE SUITE 1
EL PASO TX 79925-3413

a. NPI 1265499578 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 SEX M [ ] F [X]	4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	6. PATIENT RELATIONSHIP TO INSURED Self [ ] Spouse [ ] Child [ ] Other [X]	7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR
CITY: EL PASO STATE: TX	8. RESERVED FOR NUCC USE	CITY: EL PASO STATE: TX
ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )		ZIP CODE: 79928 TELEPHONE (Include Area Code): ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME	10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 01/31/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL. 431	15. OTHER DATE QUAL. 454 MM DD YY 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA	17a. 0B MDK4281TX 17b. NPI 1356303150	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M546 B. C. D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 01 18 19	01 18 19	11		72146		A	2250 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [X] 742930387	26. PATIENT'S ACCOUNT NO. CORDA005 143042	27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO	28. TOTAL CHARGE $ 225000	29. AMOUNT PAID $	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNATURE ON FILE SIGNED 01/31/19 DATE	32. SERVICE FACILITY LOCATION INFORMATION THE BACK NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.		33. BILLING PROVIDER INFO & PH # (915)8818264 THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.		

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA | PICA

1. MEDICARE (Medicare#)	MEDICAID (Medicaid#)	TRICARE (ID#/DoD#)	CHAMPVA (Member ID#)	GROUP HEALTH PLAN (ID#)	FECA BLK LUNG (ID#)	OTHER X (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)		3. PATIENT'S BIRTH DATE MM DD YY	SEX				4. INSURED'S NAME (Last Name, First Name, Middle Initial)
CORDERO, DAWN		07 05 1995	M F X				CORDERO, DAWN
5. PATIENT'S ADDRESS (No., Street)		6. PATIENT RELATIONSHIP TO INSURED					7. INSURED'S ADDRESS (No., Street)
1880 JOAN FRANCIS DR		Self X Spouse Child Other					1880 JOAN FRANCIS DR
CITY	STATE	8. RESERVED FOR NUCC USE					CITY / STATE
EL PASO	TX						EL PASO / TX
ZIP CODE	TELEPHONE (Include Area Code)						ZIP CODE / TELEPHONE (Include Area Code)
79928	( )						79928 ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:					11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous)					a. INSURED'S DATE OF BIRTH MM DD YY / SEX
		YES NO X					07 05 1995 M F X
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? PLACE (State)					b. OTHER CLAIM ID (Designated by NUCC)
		YES NO X					
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT?					c. INSURANCE PLAN NAME OR PROGRAM NAME
		YES X NO					FLORES TAWNEY ACOSTA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)					d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
							YES NO X If yes, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED SIGNATURE ON FILE DATE 02/20/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL 431	15. OTHER DATE QUAL 454 MM DD YY 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA	17a. 0B MDK4281TX 17b. NPI 1356303150	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? $ CHARGES YES NO X
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M24852 B. M79605 C. M7062 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE / ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

	24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1	02 06 19	02 06 19	11		99215	25	A B C	500 00	1		NPI	1356303150
2	02 06 19	02 06 19	11		20610	LT	A B C	200 00	1		NPI	1356303150
3	N4 633230165 05 ML4 02 06 19	02 06 19	11		J1100		A B C	40 00	4		NPI	1356303150
4											NPI	
5											NPI	
6											NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
742930387 X	CORDA005 143583	X YES NO	$ 740 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH #
SIGNATURE ON FILE SIGNED 02/20/19 DATE	THE BACK NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	(915) 8818264 THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.

CARRIER

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

EXHIBIT 2

FLORES TAWNEY ACOSTA PC
801 MYRTLE AVE SUITE 100
EL PASO TX 79901

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE [ ] (Medicare#) MEDICAID [ ] (Medicaid#) TRICARE [ ] (ID#/DoD#) CHAMPVA [ ] (Member ID#) GROUP HEALTH PLAN [ ] (ID#) FECA BLK LUNG [ ] (ID#) OTHER [X] (ID#)			1a. INSURED'S I.D. NUMBER (For Program in Item 1)
2. PATIENT'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN	3. PATIENT'S BIRTH DATE MM DD YY 07 05 1995 SEX M [ ] F [X]		4. INSURED'S NAME (Last Name, First Name, Middle Initial) CORDERO, DAWN
5. PATIENT'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR	6. PATIENT RELATIONSHIP TO INSURED Self [X] Spouse [ ] Child [ ] Other [ ]		7. INSURED'S ADDRESS (No., Street) 1880 JOAN FRANCIS DR
CITY EL PASO	STATE TX	8. RESERVED FOR NUCC USE	CITY EL PASO STATE TX
ZIP CODE 79928	TELEPHONE (Include Area Code) ( )		ZIP CODE 79928 TELEPHONE (Include Area Code) ( )
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)		10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER		a. EMPLOYMENT? (Current or Previous) [ ] YES [X] NO	a. INSURED'S DATE OF BIRTH MM DD YY 07 05 1995 SEX M [ ] F [X]
b. RESERVED FOR NUCC USE		b. AUTO ACCIDENT? [ ] YES [X] NO PLACE (State)	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE		c. OTHER ACCIDENT? [X] YES [ ] NO	c. INSURANCE PLAN NAME OR PROGRAM NAME FLORES TAWNEY ACOSTA PC
d. INSURANCE PLAN NAME OR PROGRAM NAME		10d. CLAIM CODES (Designated by NUCC)	d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [X] NO *If yes,* complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED SIGNATURE ON FILE DATE 04/11/19

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED SIGNATURE ON FILE

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 10 11 16 QUAL. 431	15. OTHER DATE QUAL. 454 MM DD YY 09 28 17	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ROBERT E URREA MDPA	17a. 0B MDK4281TX 17b. NPI 1356303150	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) ZZ207X00000X		20. OUTSIDE LAB? [ ] YES [X] NO $ CHARGES
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. M24852 B. M79605 C. M7062 D. E. F. G. H. I. J. K. L.		22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER

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24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1 03 29 19	03 29 19	11		99215		ABC	500 00	1		NPI	1356303150
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (For govt. claims, see back)	28. TOTAL CHARGE	29. AMOUNT PAID	30. Rsvd for NUCC Use
742930387 [ ] [X]	CORDA005 144982	[X] YES [ ] NO	$ 500 00	$	

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (915) 8818264
SIGNATURE ON FILE SIGNED 04/11/19 DATE	THE BACK NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.	THE BACK & NECK INSTITUTE 6211 EDGEMERE SUITE 1 EL PASO TX 79925-3413 a. 1265499578 b.